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ABSTRACT

Supervision is a major component of psychology training programs. This paper explores the difference between "traditional" supervision received by a doctoral clinical psychology student and "live" supervision. In traditional psychotherapy supervision, practicum experiences generally require the student to see a client and then report back to the supervisor for feedback and direction regarding the client. Often, the supervisor has had little or no contact with the client. Supervision in the traditional mode has apparent limitations because it relies heavily on the recollections and interpretations of the trainee, which may be unreliable. With direct live supervision the supervisor watches an ongoing interview, enters the session and intervenes in the therapy process. The main advantage of live supervision, although costly in terms of time and funding of faculty, is that the trainees are able to more quickly perform the expected counseling skills since immediate feedback is available. (BF)

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Enhancing the Acquisition of Psychotherapy Skills Through Live Supervision

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Running head: LIVE SUPERVISION

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Abstract

This paper, based upon a 1994 symposium presented at the 102nd Annual Convention of the American Psychological Association, explores the difference between "traditional" supervision received by a doctoral clinical psychology student and live supervision, which the author experienced in an advanced practicum placement. It was felt that live supervision, although costly in terms of time and funding of faculty, was a preferable due to the quality and intensity of the learning experience.

ENHANCING THE ACQUISITION OF PSYCHOTHERAPY SKILLS THROUGH LIVE SUPERVISION

Supervision is a major component of psychology training programs. Each graduate student is likely to have a number of different practicum supervisors throughout their graduate career. Many different supervisor variables, such as the supervisor's knowledge base, clinical skill, theoretical orientation, and personality, may influence the supervisory process, and affect the supervisor-trainee relationship (Aponte & Lyons, 1980, Stycyznski, 1980). In addition, the technique of supervision itself may also influence the amount of knowledge the trainee can receive from the supervisor.

In "traditional" psychotherapy supervision, practicum experiences generally require the student to see a client and then report back to the supervisor for feedback and direction regarding the client. Often, the supervisor has had little or no contact with the client. Supervision in the "traditional" mode has apparent limitations because it relies heavily on the recollections and interpretations of the trainee, which may be unreliable. Muslin, Burstein, Gedo, and Sadow (1967) reported that at the early stages of supervision, supervisees are unreliable in their reports of client functioning because they may miss important themes, miss client emotional responses, may misinterpret the client-therapist relationship, and thus, cut off client exploration.

If sessions are audiotaped, a supervisor cannot see what occurred, and the proliferation of camcorders has not led to a corresponding increase in the acuity of videotaped sessions, given the spatial limitations of most rooms or offices used for psychotherapy purposes.

Stein, Karasu, Charles, and Buckley (1975) compared "traditional" supervision, as described above, with a technique in which the supervisor directly observed the trainee's interactions with the client. The results suggested that when both the supervisor and trainee observed the client, they rated the client's pathology, motivation for treatment, level of insight, and prognosis more consistently than when only the trainee had seen the client. Thus, it appears that when the supervisor is able to observe the psychotherapy session, the trainee and the supervisor are better able to evaluate it. By having a supervisor who has seen the trainee's performance, it is easier for the trainee to understand the client, as well as receive feedback on skills acquired in therapy. One disadvantage with this technique is that the trainee receives feedback "after-the fact". The session has ended and opportunities for examining certain issues have passed.

Another technique that has been utilized in the past, direct "live" supervision, in which the supervisor watches an ongoing interview, enters the session, and intervenes in the therapy process (Kivlighan, Angelone, & Swafford, 1991). The more common variety of

"live" supervision occurs in marital and family therapy training, as has typically consisted of a therapist in one room with a couple or a family, and a group of peers and a supervisor in an adjoining room watching the session through one-way glass. The supervision occurs through use of a telephone in each room in which questions/concerns of peers or supervisor are brought to the attention of the therapist. There are also occasions in which the therapist is called out of the room for supervision and allowed to watch the family interact through the one-way glass during the absence.

The main advantage of live supervision over the more traditional forms of supervision such as case description, videotaping, and audiotaping is that the trainees are able to more quickly perform the expected counseling skills (Richert & Turner, 1978). Berger and Dammann (1982) stated that this enhanced performance is due to several factors. First, the supervisory feedback is immediately available, which allows the trainee to implement suggestions in a more efficient and timely fashion. These interactions assist the trainee in areas to explore or probe further. Second, the supervisor can provide *in-vivo* modeling to the trainee. In one form of live supervision, the supervisor is able to see the case "live" and can interact while the session occurs, making this a *co-therapeutic* experience. Third, the supervisor can shape the trainee's behavior by offering suggestions.

Finally, supervisory interventions can be easily built upon one another through live supervision because the supervisor and the trainee are both fully aware of the case.

Given these advantages, the question arises as to the extent to which live supervision is utilized in training programs across the country. Kaplan (1987) surveyed 23 university and 10 private institution marriage and family training programs and found that 80% required live supervision and 42% thought it to be important enough to provide a minimum of one hour of live supervision per week for each student. Kaplan (1987) observed that no one approach to live supervision seemed to dominate and found that the most common problems with live supervision related to scheduling problems and the amount of time required of faculty members to do this type of supervision. In a more recent study, Bubenzer, West, and Gold (1991) surveyed counselor education and counseling psychology programs across the country. Widespread and diverse use of weekly live supervision was found in at least 75% of the programs surveyed. This survey included marriage and family programs in which live supervision has historically been utilized, and in psychology programs that were not partialled out. This survey also found that there are two methods of live supervision utilized to a greater extent than others. The most common methods included co-therapy, in which the

supervisor is in the room with the counselor, and remote viewing via one-way mirror or a television monitor, where the supervisor phones instructions to the trainee. Twenty-five program directors indicated that they believed that live supervision was the most powerful tool for teaching. They admitted that the amount of time required to provide live supervision, as well as the need for expensive equipment, and the difficulty in scheduling were drawbacks. Trainee effects were also noted, with live supervision being seen as useful for counselor skill development, support and guidance, and the development of confidence and risk-taking on the trainee's part.

Although live supervision has received a lot of anecdotal support, little empirical research has been done on this topic. It seems that most research studies concerning live supervision have come from the area of family therapy. Fenell, Hovestadt, and Harvey (1986) compared trainees who received live supervision (i.e., supervisor viewing sessions from behind a one-way mirror) with trainees who received delayed supervision (i.e., case presentations). The researchers found no differences in the two supervisory conditions, however, methodological limitations may have affected these results. First, the study may have been affected by low statistical power due to a small number of subjects. In addition, the level of experience for the trainees was different in the two supervisory conditions.

Kivlighan, Angelone, and Swafford (1991) compared a live supervision group with a videotaped supervision group of beginning therapists. Therapists who received live supervision focused more on the support and relationship variables of psychotherapy than did therapists who received videotaped supervision. Also, the clients of the therapists who received live supervision said they had a stronger working alliance and reported their sessions were rougher than did clients whose therapists received videotaped supervision. Finally, differences were observed between the two groups in the use of limit-setting with the clients. Prior to this study, it was commonly believed that most trainees perceive therapy as a "permissive environment", and thus, had difficulty setting limits with their clients. This study found that therapists in the live supervision group were able to set more limits with their clients. The continued presence of the supervisor may have functioned as a reminder for the trainees to set limits.

It may now be time to return to direct "live" supervision in a co-therapy format in order to educate and create better qualified future practitioners (Tentoni, 1994). Although it is not often done in clinical psychology programs due to financial reasons and supervisor time constraints, it appears to be an optimal type of supervision to receive.

Live supervision was utilized in my fourth-year clinical psychology practicum training. I was placed at the student health center on the

campus of the University of Wisconsin—Milwaukee. Live supervision in a co-therapy format began almost immediately. I was allowed to sit in on some intake interviews and therapy sessions done by my supervisor. At first, I was allowed to fill a secondary role in which I could observe the progress of the sessions while minimally interacting. My supervisor conducted the sessions until I became familiar with the client populations and the objectives of brief psychotherapy.

Even though I was a student, I was never treated as such. I was treated and addressed as a "staff member", with my name on the health center central directory board from the very beginning. I was told that I could ask questions of the client at any time, and direct the process during the sessions, and that I was not only a mere observer. Over time, as I became more comfortable with my supervisor and myself, I began to interact more with the clients during the sessions. Shortly thereafter, I was scheduled for my own clients and my supervisor provided the secondary support during the sessions. Over time, he interacted less and less with the clients, and I interacted more.

In my past training, I had never experienced this type of supervision. In past practicum experiences, I had always been supervised using a delayed format in which my supervisors would watch videotapes or listen to audiotapes. Live supervision, although quite nerve-wracking at first, turned out to be an enjoyable and

rewarding experience for a number of reasons. First, there was an immense amount of learning that occurred on my part by actually seeing psychotherapy happening in my presence. I became aware of how to conduct psychotherapy by seeing it progress "at-the moment", not by reviewing a tape after the session was already ended. Second, because I was treated as an individual staff member, I was allowed to develop my own orientation toward psychotherapy. It was clear from the beginning that I was not expected to become a "clone" of my supervisor. I was encouraged to ask the clients any questions I felt necessary to formulate more of an opinion regarding the case. I was also told that if my supervisor asked a question during one of my sessions, I was not to think that I was conducting the session incorrectly, that the supervisor would ask questions to gain more information about a case. By having these "unwritten rules" reinforced numerous times during the process of learning psychotherapy, I became comfortable in the role of the therapist even though my supervisor was still in the room. Third, it was especially beneficial to discuss the sessions with my supervisor after they had occurred. Because my supervisor had experienced the sessions, I did not have to report what had occurred. It was much easier to discuss and process a case knowing that my supervisor had seen the same session that I had.

It is unfortunate that live supervision is not utilized more often in my own clinical psychology program. The benefits and the knowledge gained far outweighed the initial discomfort of having the supervisor in the same room with me. It is understandable that more programs do not use live supervision due to time constraints on the faculty members, however, the benefits far exceed the time spent in it.

From the standpoint of creating competent and qualified practitioners, it may be time to consider a return to the style of supervision done in the early days of psychology, which is to do it live.

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